Regional Stakeholder Meeting Summary
August 2011

PURPOSE

The Regional Stakeholder Meetings were designed to gather community perspectives on two proposals: Realignment, the proposed elimination of the Department of Alcohol and Drug Programs (ADP), and the transfer of ADP's remaining functions to other state departments. The intent of the Administration was to engage community members so that they can provide input to the Legislature and to the Administration on the perceived strengths and concerns of these significant proposals.

SUMMARY OF STAKEHOLDER MEETINGS

ADP developed five regional stakeholder sessions. These sessions were held in Alhambra, Redding, Rialto, Oakland and Sacramento. The sessions provided an orientation hour to review the documents that were posted on the Department's website and clarify terms/initiatives and then the sessions transitioned into an open forum that focused upon seven questions.

1. What opportunities and/or benefits to counties, providers or clients do you see as a result of these separate initiatives (Drug Medi-Cal Transfer, Realignment of programs to counties, and the proposed elimination of the Department of Alcohol and Drug Programs)?

2. What do you believe will be the greatest challenges created by these changes *(For counties, providers, clients)*? What are your recommendations to address these challenges?

3. What are the most important functions/activities/programs to be retained at the state level? Any additional ones?

4. Within which department or agency should these functions be located, and why?

5. What are the most important functions/activities/programs to be performed at *(or transferred to)* the county level? *(Are there any new ones?)*

6. What other strategies should the Department of Alcohol and Drug Programs employ to engage racially, ethnically, linguistically, and culturally diverse clients, family members, and community stakeholders?

7. How can we best continue to involve stakeholders on an ongoing basis?

In addition to the five regional sessions, ADP convened a Director's Advisory Committee special session, and held a Prevention Stakeholders conference call to capture their input. The total number of Stakeholder participants (non-ADP participants) are as follows:

- Five Regional Stakeholder Meetings: 375.
- Director's Advisory Council: 24
- Prevention Stakeholders conference call: 45.

The following is a high level summary of the participant comments, as well as those received by ADP through the Department's webpage and individual emails directed to staff.

Stakeholder Feedback

The overall comments received in the public forums recommended ADP remain as its own Department, but if that is not possible, to relocate current staff with current functions as a complete unit. Concerns were raised that current ADP functions would be parceled out with multiple locations creating new challenges – multiple departments – multiple regulations and duplicative processes.

As was expected, the diversity of opinions expressed by the stakeholders reflected roles within the alcohol and other drug (AOD)/substance use disorder (SUD) system, years of experience operating within the same, local perspectives based upon county government and State department interactions, and review of experiences / outcomes in other states / locations that had conducted similar initiatives.

Information received in the ADP-managed sessions as well as post-session responses received has been categorized under general headings that emerged through the various sessions. When feedback/suggestion(s) were not Realignment or elimination of ADP-related, input was redirected to the appropriate ADP division for review.

Question 1: What opportunities and/or benefits to counties, providers or clients do you see as a result of these separate initiatives (Drug Medi-Cal Transfer, Realignment of programs to counties, and the proposed elimination of the Department of Alcohol and Drug Programs)?

Improved Local Planning – Service Delivery Systems

- Counties are better able to determine needs and provide the services – provide counties flexibility in prioritizing and administering programs.
- Proposal provides counties with an opportunity to re-think how to structure service delivery systems.
- Functions moving to county level may create cost savings advantage by increasing consistency by streamlining processes (reporting, claim filing, billing etc.) and paperwork within both the mental health (MH) and SUD systems.
- Restructure and protect/isolate some ADP functions as the new budget/legislation is created going forward. If done right, restructuring could streamline into “no wrong door” policy.
- Improved brainstorming-problem solving between MH and SUD professionals is likely. By co-locating, they can innovate and observe results of their implemented policies.
- May provide greater access to benefits for underserved populations.
- May provide counties greater opportunities to directly improve their provider relationships and monitoring. Counties could conduct internal analysis of their systems as a whole and build in collaborative relationship in their service continuums.
- It could allow counties to independently address gaps in services not currently covered, example specifically noted was drug overdose and drug overdose prevention.
- It may provide the ability to coordinate around the full spectrum of drug user’s life, change, contemplating, making change, relapse. Roles needs to be created – a specialist that can incorporate harm reduction into treatment (Tx).

Potential for Efficiencies

- Eliminating State level costs could allow for the shifting of additional Tx resources to field level for more direct services.

Question 2: What do you believe will be the greatest challenges created by these changes *(For counties, providers, clients)*? What are your recommendations to address these challenges?

Loss of Advocacy – State level expertise with Elimination of ADP

- The blending of MH and SUD services under one division of a state department will greatly damage the AOD field; Stakeholders fear that AOD will be left behind. The service approaches now employed will be lost or morphed into lesser services that would directly affect the clients.
- Prevention (Pv) activities and services, as historically provided through the AOD system will be lost and/or become a non-issue if merged into the Department of Health Care Services (DHCS) primary mission of addressing medical conditions.
- Parceling out current ADP functions to multiple departmental homes would create new challenges and additional resources that already are pressed to maintain liaisons and rule monitoring with multiple departments for all AOD functions. Should a problem arise with the counties once the counties are given the responsibility and authority, there will not be a State department or entity to contact to address issues.
- Stigma still persists regarding AOD Tx and recovery, including within existing State departments.
- The AOD field and its constituents will lose the strong Advocate Voice that ADP provides. Stakeholders are concerned that the gains of the last 40 years will be lost, and that some counties will not serve client's AOD needs adequately. This issue is already a current problem that Stakeholders believe will get worse.
- DHCS may not have the expertise or mission necessary to effectively advocate for SUD issues.
- If ADP is disbanded and multiple departments house their functions, it may cause hardship to coordinate and collaborate at the local level, especially for smaller counties.
- ADP's ability to gather various information to help counties will be lost. If this function is pushed down to the county level, there is no central database in which to gather statewide information.
- If programs are Realigned, the loss of statewide expectations will destroy consistent quality services statewide; 58 counties doing programs 58 different ways.
- Stakeholders are concerned for the loss of lobbying from a central Department for SUD concerns. Without a separate department, that will be a problem.
- Questions around who will represent the State with the federal government regarding the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) as well as the fast approaching Affordable Care Act (ACA) and Health Care Reform (HCR) implementation.
- It has not been made clear to the field the necessity of for the elimination of ADP. Cost savings analysis has not been done. No explanation of why now it is necessity to make monumental changes in the way in which we do business, when HCR comes in 2014.
- DHCS will need to reinvent the mechanisms ADP has already established for community-based meetings and statewide policy development.
- Substantive differences in philosophy and terminology go to the heart of effective treatment.

Recommendations

- Requested Cost Analysis for Realignment – provide stakeholders the opportunity to be informed as to why this is being done, what benefits will be gleaned, and analyze the timing in reference to the 2014 implementation date of the federal ACA.
- Evaluate carefully to achieve a good match between transferred functions and new departmental homes: must have compatible goals and [field] relationships.

- As part of restructuring, remove statutory barriers to allow funds to cross-over between MH and SUD for the provision of COD services. Co-Occurring Disorders (COD) can be treated successfully, if, within a dual system, departments are careful that all staff can deal with COD–SUD, and that it is not an automatic referral to MH if a client has a COD.
- Have the Administration conduct analysis to change the way services are rendered in SUD and MH; look at both sides in an integrated way. That does not necessarily mean eliminating ADP and then hoping all 58 counties will pick up the slack.
- Create a Strategic Plan for the Realignment and Elimination of ADP processes and publish them.

New Burdens Placed upon Unequipped Counties

- The counties need external oversight and to be held accountable so that services will be equal across the state. With the proposals, the State may not have oversight authority necessary to protect clients.
- Counties are currently greatly understaffed and unable to take on new duties/ programs with current resources. Implementation success could be varied.
- Many counties are not equipped to be a "One Stop Shop" under a behavioral health model.
- With funds that will be capped, counties will not be able to absorb costs associated with growth.
- Saving money requires skills and knowledge that counties do not have.

Recommendation

- Be sure to Align county vision/practices with federal/State requirements of documentation, performance measures and data collection.

Negative Impacts to Providers with Loss of State wide Standards

- Reevaluate licensing fees.
- Concerns raised if licensing and certification functions are brought to the county level that there will be 58 different structures, 58 different fee schedules.
- Funding and support for traditional or faith-based interventions may not be an option if determined at the local level.
- If funds are lumped into one collective pot, SUD funds will be diverted to other "politically advantageous" causes, thus draining SUD completely with zero funds for those with the most need.
- Lack of transparency: "the good old boys network", some providers may be edged out of the Tx/Pv service continuum by local politics.
- Counties assessing themselves: counties cannot accurately assess what they are doing – it is a conflict of interest. This can impact both county and provider-run programs.
- Local level politics work against effective service – too idiosyncratic, unpredictable, and subject to local power politics.
- Lack of consistency in county-run programs.

Recommendation

- Create a legislative guarantee for a mandated set-aside minimum level of funds specifically for SUD Pv and Tx for every county, stipulating counties will not be allowed to redirect the SUD-specific funds into general county coffers.

Imbalance in Clinical/Funding Power between AOD / MH

- Concerns raised that the AOD Tx field will be "sucked up" by MH. It has happened repeatedly at the local level, and it will happen again at the State level.
- The term "medical model" is thrown across all systems, but training is not mentioned. The question was raised of who will provide training and where those funds will be derived from.
- If departments/functions become merged, it will be necessary to cross-train AOD and MH staff to ensure recognition of AOD specialists. Throughout the sessions, there were frequent comments about the tension between Tx approaches used by AOD/MH, and that the medical model – physician directed – was not necessarily preferred or required.
- The task of recognizing the value of all Tx approaches, and successfully integrating them, will be difficult in some counties. Several stated the medical model is not necessary in the AOD field but rather what is needed is the understanding of medical problems with SUD patients on an as-needed basis by clients.

Recommendation

- Create regional advisory committees inclusive of AOD and MH Tx providers with equal representation of professionals from both disciplines.

Fiscal Elements of the Realignment Funds

- There is no basis for the allocation – distribution of funds. Concern raised on what it will be based upon in the future – population, census, crime statistics; concern for the whole allocation process.
- There are no growth factor details in the proposal. Should growth happen and additional services be required, the plan for revisions to cover additional costs are not there.

Recommendations

- Create constitutional protections, amendments or legislative protection to guarantee these dollars in coming years, to assure sustained funding after this year, and to account for growth in future years.
- The State should mandate allocations for certain scopes of services.
- The State should require how monies should be spent in counties for specified services.
- Keep funding streams separate so that the services will receive funds. Concern that funds will be "blended" in counties and AOD services monies will end up in a "general fund pot" rather than allocated to AOD services.
- Ensure SUD services will be a political, social, and funding priority as included in Realignment clean up language.

Question 3: What are the most important functions/activities/programs to be retained at the state level? Any additional ones?

Stakeholder input from all of the regional sessions indicated strong support for leaving the majority of the existing ADP functions at the State level. The feedback resulted in a comprehensive listing of items that the field recommended for retention as well as a majority opinion of keeping these AOD/SUD functions under the authority of one entity.

Comments that related to additional functions included provider concerns that disruptions to services could result from counties' contracting and payments processes, and political decisions made locally that fail to recognize the purpose/need of AOD/SUD services.

Within all five sessions, the DAC, and through emails/correspondence, the themes for continued state level responsibilities included:

- Data collection.
- Counselor certification.
- Licensing and Certification (L&C) of Tx and residential facilities. It was noted that local administration of these functions may have the unintended outcome of reducing successful placement of facilities due to the local push back against Tx facilities located within communities ("Not In My Back Yard" concerns)
- Though most comments supported L&C remaining with the State, recommendations to consider changing fee structure for bed fees and certification fees, along with the total elimination of fees was suggested.
- Office of Problem Gambling (OPG).
- Driving Under the Influence (DUI).
- Statewide professional certifications.
- Direct contracts directly with providers for those who do not do so currently.
- Technical Assistance.
- SAPT BG allocation, oversight and accountability.
- Keep current ADP staff and transfer their positions to keep the knowledge, skills, abilities expertise. Move the group in total to whatever department will have the remaining functions regardless of where they are housed.
- State Needs Assessment Program (SNAP).
- Oversight of allocation of funds with an appropriate accountability structure to verify that AOD funds are spent on AOD services, and not lumped into the diverse board of supervisors' "pot of money" that can be reallocated when politically led.
- Oversight, audit, advocacy and standard rate setting.
- Set and enforce cultural competency standards.
- Narcotic Treatment Program (NTP) oversight and audit functions to ensure compliance and uniformity.
- ADP is more efficient for the field: stakeholders are able to go to one place to get what they need.
- Protect and ensure that such hard-won efforts as Dual Diagnosis Capability in Addiction Treatment (DDCAT) (AOD/COD integration) are not lost.
- Protect and ensure that the biennial ADP Training Conference will continue (provides great technical assistance).
- Ensure the entire provided list of functions remain at the State level, whether as an independent entity or together under another agency. Counties do not have staff, funds, expertise, knowledge or data support to do these functions.

Recommendations

- If eliminated, create a State department such as ADP to guide counties on interventions and to look closely to prescribing habits, for example, across the State to see if intervention is possible. This entity will continue to provide the field and associations with the pulse on statewide needs. The State agency needs to help to inform the Legislature and Administration to advocate for SUD issues, and to see what is required for contact with the federal government, provide best practices, and oversee and enforce minimum services statewide. Individual counties cannot do this.
- The field needs a single point of access for questions, concerns, hot button issues.

- Whatever structure is decided to house AOD/SUD, set up that board or agency or administrative functions with a board or committee that is stacked equally with AOD and MH professionals, that AOD is represented equally with MH.
- Keep all functions on provided list at State level.
- Have one statewide body overseeing regulations to ensure counties adhere to them.
- Reducing impacts to providers and county programs must be the top priority.
- No lapse in contracts or payments must be a top priority: ensure continuity of services.
- If ADP is moved or merged, keep its operational functions together, keep current employees to retain their expertise in subject knowledge and relationships with stakeholders statewide.
- Make sure AOD funds do not commingle with county general funds. Create a firewall.
- Within the new structure of ADP and MH combined, create two Deputy Directors, one for SUD and one for MH.
- Set up whistleblower protection; there is currently no whistleblower protection for counselors.

Question 4: Within which department or agency should these functions be located, and why?

The sessions yielded specific recommendations on separate components of the overall AOD/SUD services and activities continuum. There was also a general comment throughout many of the regional sessions that not enough information was available about the future strength of individual departments, funding, and missions to allow for fully informed positions.

- Move SUD Pv components to the Department of Public Health, as the public health environmental approaches to wellness and PV are more inline with the existing SAPT evidenced-based approaches.
- Move SUD Tx components to DHCS.
- Move DUI to the Department of Motor Vehicles (DMV) if not able to be effectively housed within a department with a focus/understanding of the DUI program and mission.
- Move Counselor Certification to the Department of Consumer Affairs (DCA), as this entity specializes in the setting of standards and monitoring the capabilities of the workforce.
- Recommended that licensing and certification of facilities ARE NOT considered for transfer to the Department of Social Services.
- Propose the State level functions to be in a joint SUD/MH agency at a policy level similar to SAMHSA – perhaps call it “California SAMHSA”.

Recommendation
- The department as a whole and/or all individual components should remain State functions.

Question 5: What are the most important functions/activities/programs to be performed at *(or transferred to)* the county level? *(Are there any new ones?)*

- Regional resource centers and the internet will supply the need for any resources; a State Resource Center is no longer necessary.
- If it must be moved, counties could oversee certifying and licensing of their own facilities to expedite the process with State oversight to guarantee compliance and uniformity.
- County level monitoring of providers.
- A frequent set of comments involved the extent to which local control of service levels, program benefits in excess of the federal requirements, and flexibility on where services are provided; these recommendations would need to be managed within discussions related to the federal requirements of the Drug Medi-Cal program and the SAPT BG.

Recommendation

- Certification and licensing should be moved to the county level but retain State oversight to ensure accountability and enforcement.

Question 6: What other strategies should the Department of Alcohol and Drug Programs employ to engage racially, ethnically, linguistically, and culturally diverse clients, family members, and community stakeholders?

- Native American and other cultural belief systems that do not adhere or work well under the "medical model" must be retained in their own right to provide services, prevention, treatment and recovery options that are open to "alternative medicine" avenues.
- All materials in person and online should be American's with Disability Act (ADA) accessible.
- Contact recovery alumni groups to encourage/promote more public statements from people in recovery, especially people in the public eye. Many who are in the public eye still fear harming their careers by being open about their successful recovery stories. This helps influence decisions about using public resources.
- Disseminate information about proposed changes to minority groups, online, publications, local news papers.
- Check with DMH to use their networks.
- The State could do a better job of outreach to special communities that are not represented by Census information.
- Work with previous technical assistance contacts to ensure cultural competency across the board.
- Special populations: Retain linguistic staff to engage in SUD and provide services appropriate for every population. Assure counties provide evidence-based multi-lingual, representative of communities, best practices.

Question 7: How can we best continue to involve stakeholders on an ongoing basis?

- Employ social media – FaceBook, Twitter, etc., and create a robust website similar to OPG to engage the public and clients in these changes. Create a very general discussion in these venues.
- Set up regional advisory comprehensive workgroups for Pv, Tx, and recovery.
- Use the Culturally and Linguistically Appropriate Services (CLAS) Project data gathered on how to reach rural communities for outreach to those communities.
- Create survey questions that are more specific and lay-person friendly.
- Outreach to the business community educating them on public/ethical responsibility as to how not to promote "bad products."
- Communicate via email.
- Continue coordination of biennial ADP Training Conferences.
- Pv is currently doing an excellent job getting communication out to the field; adopt their level of customer service statewide.
- Regional coalition is a good idea for stakeholder involvement.

Recommendation

- The State should convene regularly scheduled regional stakeholder meetings statewide.